Payment Error Rate Measurement (PERM)

Provider Open Door Forum
Conference Call: Wednesday
May 26, 2010

(800) 603 – 1774/Conference ID # is 75316503

3:00 – 4:30PM. EST

Presented by

Provider Compliance Group

Office of Financial Management

Centers for Medicare & Medicaid Services

OFFICE OF FINANCIAL MANAGEMENT

Integrity Stewardship Service

Purpose of the Open Door Forum call

- CMS is conducting "Open Door Forum Conference Calls" to educate the provider community about the PERM program and their responsibilities.

- The accuracy of your State's payments is currently being measured; therefore, we want to raise your awareness of the requirements before you are contacted.

- During this presentation, CMS staff and partners will share information with you and you will have an opportunity to ask questions.

- The Open Door Forums will serve as one of the many ways for the agency, the States and our healthcare partners to advance our combined goal of accurate documentation and reducing improper payments.

PERM: What Is It?

- In 2002 , Congress enacted the Improper Payments Information Act (IPIA). The IPIA requires that programs susceptible to improper payments measure and report improper payments annually.
- The PERM program was developed to measure improper payments in Medicaid and CHIP.
- The first measurement of Medicaid FFS improper payments was completed in 2006.
- CMS and HHS report improper payments annually in the Agency Financial Report (AFR) http://www.hhs.gov/afr/
- Measurement of CHIP improper payments is on hold due to the development of a final regulation as required by Section 601 of Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).

PERM: What Is It? continued..

- CMS uses a 17-state rotation for PERM. Each state is reviewed once every three years. This rotation allows States to plan for the reviews as they know in advance when they will be measured.
- We are beginning review of the following States:
  - Alabama, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Vermont, and West Virginia.
- For each State under review, a sample of claims is pulled and reviewed. Therefore, not every provider will be contacted to provide medical documentation; only those providers that provided services for the sample of claims pulled.

How Is PERM Performed?

Collection of State Policies

The PERM Review Contractor collects State Medicaid and CHIP Program Policies from each state under review from March through September of each Cycle. The following process is used:

- **Policies are obtained from web site searches on each State's web site for all provider types.**
- **Policy questionnaires are sent to States for any clarifications needed.**
- **Supplemental policies are provided by States for any policies that may not be on their web sites.**
- **States validate the master list of policies collected by the PERM Review Contractor to assure that all policies have been indentified before medical review begins.**

Medical Record Requests

- Medical records are requested from the provider by the PERM Review Contractor for all fee for service claims in the sample.
- Customer Service Representatives (CSRs) will call all providers in the sample and explain the purpose of the call and the right for CMS to collect medical records for audit purposes.
- CSRs will identify which patient's record is needed for review for a specific data of service that matches the provider's claim.
- After confirming that the correct provider has been reached and the location of the medical record needed, a written request will be faxed to the provider's office.
- The request will specify the type of documents that are needed for each claim type and will provide instructions for how to submit records to the PERM Review Contractor.

Timeframe for submission

- Providers will have 60 calendar days to submit requested record.
- Reminder phone calls and written requests will be sent to providers during this 60 day period if records have not been received.
- once the provider has submitted the initial documentation, the 60 day timeframe **stops**.
- If additional documentation is needed, Providers have **15** days to send in the additional documentation.

Important Note: *This is not an extension of the 60 day timeframe.*

Importance of submitting patient record

- **All claims with no documentation or insufficient documentation from the provider will be determined to be paid in error.**

- **If determined an error, State Medicaid Agencies will recover payment made to providers.**

- **Missing records will adversely affect the error rate.**

Medical Review

- **All submitted medical records will be reviewed by registered nurses and certified coders from September through July of each cycle.**
- **Determinations will be made of proper payment based on documentation in the record and States' policies for coverage and required documentation.**

Frequent Mistakes in Submitting Medical Records

- **Not responding within required timeframes.**
- **Submitting records for the right patient but for the wrong date of service requested.**
- **Submitting records for the wrong patient.**
- **Not submitting readable records – ie. poor quality of faxed documents.**
- **Not copying both sides of two sided pages.**
- **Marking/highlighting certain parts of the record which obscures important facts.**

Importance of Provider Documentation

- **Accurate PERM measurements cannot be produced without provider cooperation in submitting documentation.**
- **A correct finding of proper payment cannot be made without the medical record from the provider.**
- **All records are equally important even those for low dollar claims.**
- **All error findings will adversely impact the State and National error rate calculations.**
- **No documentation and insufficient documentation error findings are the largest source of errors in the past PERM measurements.**

Communication & Collaboration

- **Website** - http://www.cms.hhs.gov/PERM
- The “providers” page was developed to help providers better understand the PERM process and what you may be required to do during a PERM review.

- The provider FAQ section contains answers to the questions that are most commonly asked by providers. Also, as a provider, you may be part of an audit separate from the PERM review. Please follow the links on the provider page for more information pertaining to the recovery audits and Medicaid integrity audits.

- PERM providers are encouraged to contact their State PERM Liaisons and additionally may e-mail PERMProviders@cms.hhs.gov for any provider specific questions.

Questions